

**WELL CHILD EXAM - ADOLESCENCE****- 14 YEARS**

(Meets EPSDT Guidelines)

DATE

ADOLESCENCE: 14 YEARS

ADOLESCENT TO COMPLETE ABOUT SELF	CHILD'S NAME		DATE OF BIRTH																								
	ALLERGIES		CURRENT MEDICATIONS																								
	ILLNESSES/ACCIDENTS/PROBLEMS/CONCERNS SINCE LAST VISIT																										
	<table><tr><td>YES</td><td>NO</td><td></td><td>YES</td><td>NO</td><td></td></tr><tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>I eat breakfast every day.</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>I am happy with how I am doing in school and/or at work.</td></tr><tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>I have someone I can talk to.</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>I get some physical activity every day.</td></tr><tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>I have questions about sexuality.</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>I get enough sleep; _____ hours per night.</td></tr></table>				YES	NO		YES	NO		<input type="checkbox"/>	<input type="checkbox"/>	I eat breakfast every day.	<input type="checkbox"/>	<input type="checkbox"/>	I am happy with how I am doing in school and/or at work.	<input type="checkbox"/>	<input type="checkbox"/>	I have someone I can talk to.	<input type="checkbox"/>	<input type="checkbox"/>	I get some physical activity every day.	<input type="checkbox"/>	<input type="checkbox"/>	I have questions about sexuality.	<input type="checkbox"/>	<input type="checkbox"/>
YES	NO		YES	NO																							
<input type="checkbox"/>	<input type="checkbox"/>	I eat breakfast every day.	<input type="checkbox"/>	<input type="checkbox"/>	I am happy with how I am doing in school and/or at work.																						
<input type="checkbox"/>	<input type="checkbox"/>	I have someone I can talk to.	<input type="checkbox"/>	<input type="checkbox"/>	I get some physical activity every day.																						
<input type="checkbox"/>	<input type="checkbox"/>	I have questions about sexuality.	<input type="checkbox"/>	<input type="checkbox"/>	I get enough sleep; _____ hours per night.																						
WEIGHT KG/OZ. PERCENTILE		HEIGHT CM/IN. PERCENTILE		BLOOD PRESSURE																							
<input type="checkbox"/> Review of systems <input type="checkbox"/> Review of family history																											
Screening:																											
Hearing Screen																											
MHZ R L																											
4000 . . .																											
2000 . . .																											
1000 . . .																											
500 . . .																											
Vision Screen																											
R 20/ L 20/ .																											
N A																											
Development <input type="checkbox"/> <input type="checkbox"/> .																											
Behavior <input type="checkbox"/> <input type="checkbox"/> .																											
Social Emotional <input type="checkbox"/> <input type="checkbox"/> .																											
Physical:																											
General appearance N A . N A .																											
Skin <input type="checkbox"/> <input type="checkbox"/> . <input type="checkbox"/> <input type="checkbox"/> .																											
Head <input type="checkbox"/> <input type="checkbox"/> . <input type="checkbox"/> <input type="checkbox"/> .																											
Eyes <input type="checkbox"/> <input type="checkbox"/> . <input type="checkbox"/> <input type="checkbox"/> .																											
Ears <input type="checkbox"/> <input type="checkbox"/> . <input type="checkbox"/> <input type="checkbox"/> .																											
Nose <input type="checkbox"/> <input type="checkbox"/> . <input type="checkbox"/> <input type="checkbox"/> .																											
Oropharynx/Teeth <input type="checkbox"/> <input type="checkbox"/> . <input type="checkbox"/> <input type="checkbox"/> .																											
Neck <input type="checkbox"/> <input type="checkbox"/> . <input type="checkbox"/> <input type="checkbox"/> .																											
Nodes <input type="checkbox"/> <input type="checkbox"/> . <input type="checkbox"/> <input type="checkbox"/> .																											
Mental Health <input type="checkbox"/> <input type="checkbox"/> . <input type="checkbox"/> <input type="checkbox"/> .																											
Describe abnormal findings:																											
.																											
.																											
.																											
NEXT VISIT: 16 YEARS OF AGE																											
HEALTH PROVIDER SIGNATURE																											
HEALTH PROVIDER ADDRESS																											
Diet _____																											
Sleep _____																											
<input type="checkbox"/> Dental Referral <input type="checkbox"/> Tb <input type="checkbox"/> Cholesterol <input type="checkbox"/> Hgb/Hct																											
<input type="checkbox"/> Review Immunization Record																											
Health Education: (Check all completed)																											
<input type="checkbox"/> Nutrition/Weight Control <input type="checkbox"/> Dental Care <input type="checkbox"/> Adequate Sleep																											
<input type="checkbox"/> Development <input type="checkbox"/> Seat Belt <input type="checkbox"/> Helmets <input type="checkbox"/> Smoking																											
<input type="checkbox"/> Regular Physical Activity <input type="checkbox"/> Abstinence/sex education																											
<input type="checkbox"/> Suicide/Depression <input type="checkbox"/> Drugs/Alcohol <input type="checkbox"/> Self Exam																											
<input type="checkbox"/> Injury Prevention/Safety <input type="checkbox"/> STD/HIV/AIDS																											
<input type="checkbox"/> After school supervision																											
Assessment: _____																											
.																											
.																											
.																											
.																											
.																											
.																											
.																											
IMMUNIZATIONS GIVEN																											
REFERRALS																											
HEALTH PROVIDER NAME																											
HEALTH PROVIDER ADDRESS																											

ADOLESCENCE: 14 YEARS

Caring For Your Health at 14 Years

Milestones

Ways you are developing between 14 and 16 years of age.

You should have regular hearing and vision checkups. Talk with the doctor at each visit about your health and about your body. Now is the time to learn how to keep healthy and what to do, if you have a cold, an earache, or the flu.

You should see a dentist every six months. Ask the dentist about any changes in your teeth or enamel. Pitting in the enamel of your teeth should be shown to both the doctor and the dentist.

Growth is individual. Ask your parents when they grew. Chances are you will grow at about the same time your parents did, not when your friends grow.

For Help or More Information

For Suicide Prevention Information

Contact: National Crisis Helpline 1-800-999-9999 or Boys Town National Crisis Line 1-800-448-3000.

Sexuality Information For Teens:

www.teenwire.com.

For information about gay and lesbian

teens contact: PFLAG (Parents, Families, and Friends of Lesbians and Gays) www.pflag.com or 202-467-8180.

For eating disorders contact:

www.allabouteatingdisorders.com.

For health transition information for teens with special health needs/disabilities:

<http://depts.washington.edu/healthtr/>

Healthy Things You Can Do

Exercise, even in addition to school PE classes, is important. This should be a regular habit like brushing your teeth.

A healthy diet is important. You need certain foods for growth during your teen years. You can do serious harm to your body by dieting.

If you are worried about your weight, check with the doctor. There are charts that can give your correct weight for your height. At this age, diet for weight loss should be done only with a doctor's or a nurse's help. Exercise, healthy foods, and fewer snacks are the best ways to loose weight.

A teenager can be very emotional. This is part of the growth process. You can learn to manage stress and anger. You could take a class with a friend or your parents to learn conflict resolution skills.

Everyone feels depressed at some time. It is a serious problem if it lasts for more than two weeks. If you, or someone you know has several of the following signs, see your doctor or find a counselor.

- Noticeable changes in eating or sleeping habits. They gain or loose weight. They either can't sleep or sleep all of the time.
- Drastic personality change, or unexplained, unusually severe, violent or rebellious behavior.
- Withdrawing from family or friends, running away, always bored and/or difficulty concentrating and/or unusual neglect of appearance.
- Drug and/or alcohol abuse.
- Unexplained drop in the quality of schoolwork.
- A focus on themes of death, giving away prized possessions.
- Talking about or threatening suicide or making plans, even jokingly, or attempting to kill oneself or others.

Safety Tips

Use of safety equipment, helmets, pads, and seat belts. It is the grown up thing to do. Remind your friends.

Guidance to Physicians and Nurse Practitioners for Adolescence (14 years)

The following highlight EPSDT screens where practitioners often have questions. They are not comprehensive guidelines.

Tuberculosis Screen

Screen for these risk factors:

- Adolescent is in a household with people with tuberculosis or is in close contact with someone with the disease.
- Adolescent is in close contact with recent immigrants or refugees from countries in which tuberculosis is common (e.g., Asia, Africa, Central and South America, Pacific Islands); migrant workers; residents of correctional institutions or homeless shelters or persons with certain underlying medical disorders.

Hemoglobin/Hematocrit (Hgb/Hct) Screen

- Using your own practice experience, evaluate the need, timing and frequency of hematocrit tests, especially in menstruating teens.

Urinalysis Screen

- Using your own practice experience, evaluate the need, timing and frequency of urinalysis. Use dipsticks combining the leukocyte esterase and nitrite tests to detect asymptomatic bacteria.

Screens for Sexually Active Teens

- Gonorrhea/chlamydia.
- Pap smear.
- Human immunodeficiency virus (HIV).

High Risk Behavior

Discuss behaviors such as these:

- Depression.
- Drugs.
- Smoking.
- Sexual contacts (and need for protection and contraception).
- Suicide.
- Guns.

Notes: Immunization schedules are from the Advisory Committee on Immunization Practice of the U.S. Centers for Disease Control and Prevention.